CONTEMPORARY ARTICLE

# Motivating Persons Living with Diabetes for Insulin/Injectable Therapy

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ABSTRACT

Motivating patients to initiate or intensify insulin is a challenging aspect of diabetes practice. This paper reviews certain motivational strategies and methods used for insulin initiation/intensification. It places various domains of motivational interviewing in perspective, under a single umbrella, making it easier for practitioners to understand the art and science of insulin motivation.

**Keywords:** Diabetes, insulin therapy, patient-centered care, person-centered care, psychosocial aspects

## Introduction

A large proportion of patients with diabetes is poorly controlled, and suffers an unnecessary burden of poor glycemic control before their therapy is up-titrated or intensified.[1] While many reasons have been put forward for this clinical inertia, one of the major reasons is physician's inability (or their self-perceived inability) to motivate patients to initiate or intensify insulin therapy.[2]

The model we share in this article is being used with success at our centers. It is a simple and easily replicable method, which can be learnt by physicians and paramedical staff alike, and used in resource-limited or time-challenged settings as well as in optimal health care environments.

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## Insulin Motivation – 'WATER' Approach

The WATER approach[3] is a mnemonic coined for a method of motivational interviewing (MI) used at our centers. It is a checklist designed to remind the health care practitioner about the basics of MI, and to ensure good quality provider – patient bonding so that optimal therapeutic outcomes are achieved (Box 1).

**Box 1.** The WATER Approach

| | |
|---|---|
| W – **Welcome warmly** | • Body language<br>• The OPD encounter |
| A – **Ask and assess** | • Identifying and using cues<br>• Internal, external, laboratory<br>• Hierarchy of questioning<br>• The insulin encounter |
| T – **Tell truthfully** | • Mid-Sentence analysis<br>• Verbal/Nonverbal cues<br>• Analogy building |
| E – **Explain with empathy** | • Examples/Experience– sharing<br>• Demonstration<br>• Coping skills training |
| R – **Reassure and return** | • Agree upon the next visit/contact<br>• End with positivity |

W stands for 'Welcome warmly', which reminds the health care provider (HCP) to greet the patient, with genuine warmth, in a gender, age- and socio-culturally appropriate manner.

### Body Language

The physician should make a conscious effort to learn the nuances of body or nonverbal language, make the patient feel at ease, diagnose his or her level of comfort, and plan further conversation or therapeutic intervention. A pleasant greeting is followed by a detailed history taking, reflected by A for Ask and Assess. The patient is asked for his or her perception of diabetes. History is accompanied by an assessment of barriers to insulin therapy, cues[4] (such as concerns, symptoms, signs, laboratory reports and external influences), which may stimulate insulin use and felt needs of the patient.

### Hierarchy of Questioning

Using the correct order of questioning is of utmost importance in history taking, if one wants to motivate a major change in health-related behavior, e.g., insulin use. While conversing, one should slowly move from the patient's comfort zone to his or her non-comfort zone, from non-personal to personal, from familiar to unfamiliar. One should first identify and/or create a major felt need, and then position insulin as the treatment for that need, while focusing on its positive benefits.

A conversation where the doctor asks about sexual function or financial issues before talking of weight loss or asthenia will be not welcomed by most patients.

### Cues

The motivation model utilizes 'internal' and 'external' cues, gleaned from an intensive history taking, and 'laboratory' cues, taken from investigation reports, for insulin motivation. Internal cues are signs and symptoms, which have a high index of perceived severity, or are a 'felt need' for the patient, such as a frozen shoulder, recurrent urogenital infection or weight loss. External cues may be motivation by 'social' or 'environmental' factors. An impending or developing renal failure due to diabetes, or a child learning about the complications of diabetes at school, may act as a factor for insulin acceptance. Laboratory results such as a high HbA1c or a high vibration perception threshold on biothesiometry can be utilized for insulin motivation.

### Mid-Sentence Analysis

During the process of "asking and assessing", one can keep a close watch on the patient's verbal language or nonverbal cues, to assess the patient attitudes towards insulin. For example, one can start a sentence as "Guidelines tell us to begin insulin in you ……" and wait to see the patient's response. If he or she moves backwards or says "But I will never take insulin!" or makes a wry face, the sentence can be completed as "……. but let us try tablets for 2 weeks. Do you mind taking an expensive tablet with only 2 years history of experience?"

If on the other hand, the patient keeps a neutral stance and facies, one can complete the conversation as: "…, so let us begin twice daily insulin."

Such a mid-sentence analysis is an effective tool of reducing "counseling casualties" and getting resistant patients to gradually accept insulin or other appropriate therapy.

One should T (Tell the truth) to the patient after having assessed his needs. The truth or HCPs clinical opinion should be told in an appropriate manner, described as the five-pointed CARES approach (Box 2). These are the five attributes, which a diabetes care professional must possess.[5]

Telling the truth alone is not enough; one should Explain the situation with empathy. Explanation is accompanied by analogy building,[6] quotation of examples and use of demonstration devices. Cues gleaned during history are utilized to provide a starting point for patient engagement, and given back to patients, paraphrased as suggestions or solutions.

The last step is R (Reassure and Return). Reassurance is essential to ensure that the patient returns for follow-up.

The physician may not succeed in motivating the patient for insulin or injectable therapy during the first OPD encounter, but will at least shift him or her from the pre-contemplation to the contemplation phase (Prochaska's theory of knowledge).[7]

**Box 2.** The CARES Approach

| |
|---|
| Confident Competence |
| Authentic Accessibility |
| Reciprocal Respect |
| Expressive Empathy |
| Straightforward Simplicity |

### Experience – Sharing with Peers

Most oriental cultures encourage sharing of illness-related experiences with friends and community. Health is usually not reviewed as a private matter, unlike in western cultures. Depending upon social mores, one can use examples of successful insulin initiators in the community to encourage insulin initiation and intensification.

### Coping Skills Training

Reassurance is combined with coping skills training (CST), which helps the patient handle the stress of diabetes in a better manner.

Coping skills training is a method of improving the method(s) by which a person responds to a seemingly insurmountable challenge (for example, living with diabetes, controlling diabetes). Each and every person has both positive and negative coping skills. Our model of diabetes counseling focuses on diagnosing a particular patient's coping methods. One should begin by Asking and assessing the individual's current coping styles. This gives an idea of the negative skills which have to be Eliminated, before positive coping mechanisms can be Introduced and Internalized. These changes have to be Observed on a Ongoing basis, so that one can continually Upgrade one's Understanding and health care-related behavior. This has been termed the AEIOU approach.[8] Table 1 lists the common coping styles that can be identified and optimized.

**Table 1.** Coping Styles

| | |
|---|---|
| **Negative** | • Blaming oneself, e.g., I have developed diabetes because of sins in my past life<br>• Blaming others, e.g., my sister didn't take care of me so I developed high blood pressure<br>• Extremely bad thoughts, e.g., I will die due to high glucose<br>• Pervasive bad thoughts 24 x 7, e.g., Thinking only and only about diabetes throughout the day |
| **Neutral** | • Acceptance, e.g., I accept that diabetes and insulin are a part of my life |
| **Positive** | • Put in perspective, e.g., Let me count my blessings and strengths<br>• Positive spin-off, e.g., Insulin will make me more disciplined in my life<br>• Pleasant thoughts, e.g., May be I will make new friends at the next diabetes advocacy meeting<br>• Plan for the future, e.g., Let me begin saving money to buy an insulin pump |

### Reducing Discomfort of Change

One should always strive to reduce the discomfort associated with change.[9] Simple steps such as building a rapport with the patients, abbreviating bad news, and expanding good news, making change appear as if it were a choice, handing overcharge to the patient, and breaking the change into small bits, help in reducing the discomfort associated with change of lifestyle or pharmaceutical modality.

### Conclusion

This article tries to encapsulate, under one umbrella, the various facets of patient motivation for insulin or injectable therapy in people with diabetes. It should sensitize physicians and other diabetes care professionals to the science behind the art of insulin motivation, and help improve the quality of care provided to persons living with diabetes, by reducing clinical inertia as well as patient resistance related to insulin usage.

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